Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	011950	A. BUILDING _____ B. WING _____	11/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS HOME HEALTH CARE INC	1009 WABASH AVE TERRE HAUTE, IN 47807

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments This visit was for a home health state licensure survey. Survey dates: 10/30 and 31 and 11/1/12 Facility: #011950 Medicaid Vendor : Surveyor: Marty Coons, RN, PH Nurse Surveyor Total census-36 Home Visits-3 Record Review-5 Meadows Home Health Care Inc. is in compliance with 410 IAC Article 17 requirements for home health agencies. Quality Review: :Joyce Elder, MSN, BSN, RN November 8, 2012	N 000		

Indiana State Department of Health

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE